TESTIMONY OF
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BEFORE THE
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COMMITTEE ON VETERANS' AFFAIRS
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Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss our experience as it relates to the "Service Members Seamless Transition into Civilian Life – our Hero's Return." My name is Dr. Steven Scott and I have been a specialist in Physical Medicine and Rehabilitation since 1980. I have been employed at the James A. Haley Veterans Hospital in Tampa, Florida since 1990 and have directed both the spinal cord and traumatic brain injury (TBI) programs.

Polytrauma Rehabilitation Care

I would like to provide you with a brief history of the development of polytrauma rehabilitation care. In the summer of 2003, we began to receive these unique patients who had been evacuated from the battlefield following Improvised Explosive Device (IED) blast injury. Due to tremendous advancements in military care, we now have the opportunity to rehabilitate young men and women who in years past would not have survived. These patients are medically complex and have sustained numerous injuries which are complicated by serious TBI. The primary focus of the polytrauma system of care has been to provide rehabilitation care to the most seriously injured. A typical patient has TBI, vision and/or hearing loss, pain, wounds, burns and orthopedic problems (including amputations). We deal with extended families in crisis, including spouses, children of all ages, parents, siblings as well as other caregivers. The stress and sacrifice of the family frequently takes its toll, sometimes resulting in conflict and serious marital issues.

The complexity of injuries to these combat veterans was unlike those seen previously. The unique needs of these patients required rapid realignment of our delivery of care to routinely include a multidisciplinary team of medical specialists. In addition to our team of physiatrists or physicians who specialize in physical medicine and rehabilitation, we also have specialists in surgery, neurosurgery, internal medicine, psychiatry, infectious disease, prosthetics, orthotics, and spinal cord injury as part of the day-to-day planning and patient care. Physiatrists also lead an interdisciplinary rehabilitation team consisting of physical therapists, occupational therapists, speech therapists, rehabilitation nurses, kinesiotherapists, vocational therapists, social workers, neurophysiologists, psychologists, advance nurse practitioners, wound care nurses, respiratory therapists, recreational therapists, rehabilitation counselors, military liaisons, chaplains, blind

occupational therapy case managers, physical therapy amputee case managers, social worker case managers, education specialist and veteran benefit specialist. Each one of these medical specialties and health care disciplines has specialized expertise in caring for the polytrauma patient and family and are essential to be sure that their comprehensive care results in excellent outcomes.

Transition between DoD and VA Polytrauma

As we developed the program, it became essential to establish a mechanism to exchange medical information. Initially we established physician to physician phone conferences to National Naval Medical Center in Bethesda, Maryland, and at the Walter Reed Army Medical Center (WRAMC) in Washington, DC. Videoconferencing with patient and family members in attendance was established with Brooke Army Medical Center in San Antonio, Texas, and the National Naval and WRAMC. A military treatment referral form is completed by the military and sent to the on-site case manager DOD-VA military liaison social worker. This form initiates the referral to the Polytrauma System of Care. Medical record exchanges occurred between the Tampa VA and the military treatment facilities (MTFs). This was a new practice for us, and we have progressively improved the process. We continue to work on improvements in the transfer of radiological images and microbiology lab results. The VA Polytrauma Rehabilitation Centers (PRCs) have been an active participant in the video-conference Trauma Continuum of Care with the DoD which established improved practices in the care and transportation of trauma patients. In addition, we were able to connect to the Patient Joint Tracking System allowing us to get more detailed medical information.

Most polytrauma patients remain on active duty during their entire stay at the Tampa PRC. Therefore, ongoing information sharing between VA PRCs and DoD is necessary. The military liaison assigned to the PRC assists the patient and family with military issues and assists with the maintenance of non-medical attendant orders which pay for family members to stay at the bedside. Patients are frequently referred back to the MTF for follow-up surgery or placement in medical hold.

Polytrauma Focus on Transition

A military greeting team and case manager meets the patient and family on arrival in Tampa. Community volunteers arrange free housing and transportation to families through the Haley House Fund. Our 7-day/week program for both patients and families always has community reentry as its primary goal. Our staff and volunteers provide family education classes, family support groups and planned family activities such as “Spouses’ Day Out”, trips to NASA, etc. Our internet café provides activities outside structured therapy time. Recreational therapy provides community re-entry activities such as shopping and recreational activities. The patient and family advance in their rehabilitation to have day passes and eventually weekend overnight passes to practice their independence in community settings.

Transition to Home

The first step for our more independent patients is the Polytrauma Transitional Day Program. The patient and family move into private housing in the Tampa Bay area and continue to participate in group and individual therapies for three to six months or more depending on their needs. A comprehensive work therapy program places individuals in community jobs to help develop vocational skills. If the patient transitions to veteran status, he or she can become a candidate for the Chapter 31 Independent Living Benefits.

When the active duty individual is prepared to leave Tampa, our rehabilitation team and the patient and family meet to exchange information by video conferences with the Polytrauma Network site closest to the patient's home. Our case managers continue to follow the patient and family via phone and work closely with the MTF case manager on appropriate follow-up. The Network Site case manager and team provide progress reports to the Tampa VA on a monthly basis via video conferencing. Most patients are transitioned to home as active duty and may continue as such for up to one to two years. As active duty service members, additional authorization numbers are required by Tri-Care for continued rehabilitation therapies and medical care. Patients are encouraged to return to the Tampa Polytrauma Outpatient Program at any time.

Conclusion

I am honored to serve these courageous young men and women and their families. I look forward to working with DoD, Congress, our VA leaders, advocacy groups, and private citizens to continue to provide excellent care and to improve future care throughout the lifespan for America's wounded heroes.